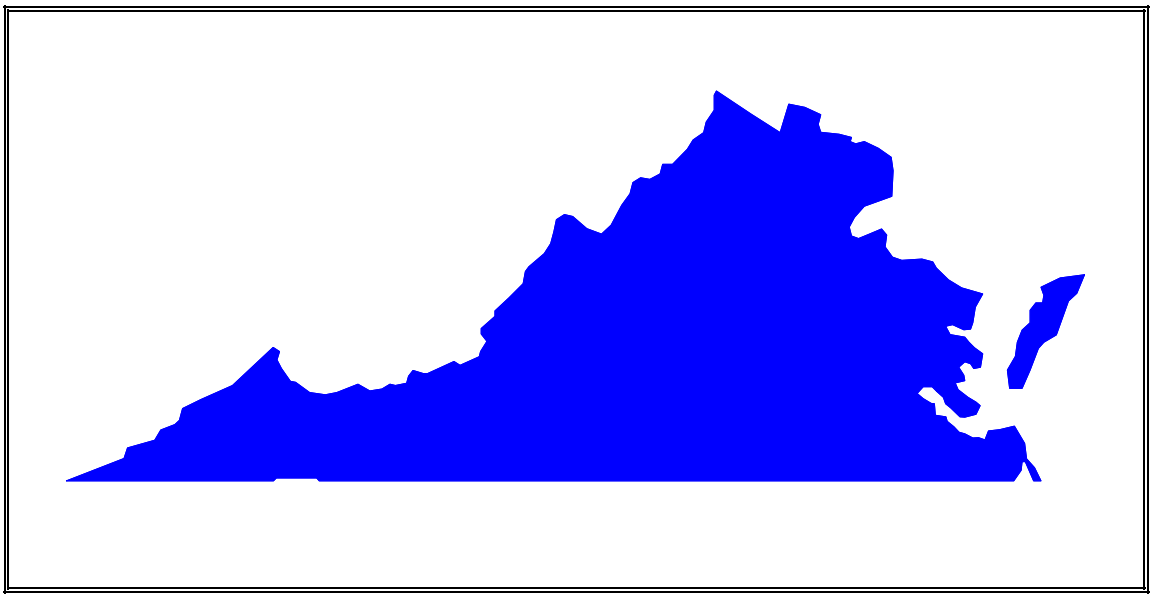
Virginia Department of Medical Assistance Services

Companion Guide

For National Council for Prescription Drug Programs – Batch Transaction

Document Version 1.4 Updated 06/17/2010



NCPDP Batch Transaction
VERSION 1.1

CONTACT INFORMATON

Mail Original to: **ACS State Healthcare, LLC**
EDI Coordinator
Virginia Medicaid Fiscal Agent Services
P.O. Box 26228
Richmond, VA 23260-6228
1-866-352-0766

Fax to: **1-888-335-8460**

Email to: **Virginia.EDISupport@acs-inc.com**

VERSION CHANGE SUMMARY

VERSION NO.	DESCRIPTION	DATE
Version 1.0 –	Original Implementation	05/15/03
Version 1.1 - **NPI modifications** Added NPI Notes in the ***Important Information*** Section. Modified comments regarding provider number and qualifier Transaction Header Segment – Service Provider ID Qualifier Transaction Header Segment – Service Provider ID Prescriber Segment – Prescriber ID Qualifier Prescriber Segment – Prescriber ID		12/01/06
Version 1.2 – Changed for Contingency Dual use Period.		06/06/07
Version 1.3 – Changed for NPI Compliance Removed highlighting from previous version. Modified NPI Notes in the ***Important Information*** Section. Modified comments in the ***Transaction Format Information*** Section. Modified comments in the ***Batch Transaction Submission*** Section. Modified comments regarding provider number and qualifier Transaction Header Segment – Service Provider ID Qualifier Transaction Header Segment – Service Provider ID Prescriber Segment – Prescriber ID Qualifier Prescriber Segment – Prescriber ID		03/19/08
Version 1.4 – ACS VAMMIS Fiscal Agent Implementation Change Re-branded documentation for ACS Modified Special Notes to include File Transfer Protocol information		06/17/2010

INTRODUCTION

The NCPDP Batch Transaction document defines the record for batch prescription claim transactions between the pharmacy and the Virginia Medicaid drug program administered by Affiliated Computer Services, Inc. (ACS). This guide provides the basic requirements for implementation of the NCPDP Version 1.1 transaction.

This Companion Guide is to be used by retail pharmacies and Managed Care Organizations for the programming of the file that is required to electronically submit data.

The National Council for Prescription Drug Programs (NCPDP) is a non-profit organization formed in 1976. It is dedicated to the development and dissemination of voluntary consensus standards that are necessary to transfer information that is used to administer the prescription drug benefit program.

To request a copy of the Telecommunication Batch Standard Formats or for more information contact the National Council for Prescription Drug Programs, Inc. The HIPAA implementation guide can be accessed at: www.ncpdp.org. The contact information is as follows:

National Council for Prescription Drug Programs, Inc.
4201 North 24th Street
Suite 365
Phoenix, Arizona 85016
(602) 957-9105
www.ncpdp.org

PURPOSE

This guide is concerned with the processing of batch requests and responses submitted to Affiliated Computer Services, Inc. (ACS) as the Fiscal Agent and information source for Virginia Medicaid. ACS adheres to all HIPAA standards and this guide contains clarifications and requirements that are specific to transactions and data elements contained in various segments.

This NCPDP implementation companion guide will provide assistance in the development and execution of the electronic transfer of pharmacy batch transaction data.

All specifications in this document conform to NCPDP Version 5.1 Telecommunications Standards and NCPDP Version 1.1 Batch Standards, adopted for use by the Virginia Medicaid. These specifications are designed to be compatible with currently existing communications networks.

SPECIAL NOTES

ACS uses the MOVEit® DMZ application to transmit batch EDI data into the Virginia Medicaid system. All Service Centers must have applied and been authorized by the Virginia EDI Coordinators office before using MOVEit® DMZ.

- **How to use MOVEit® DMZ Application tool for secure file Drop off and Pick up**

MOVEit® DMZ is a secure file transfer and secure message server. It is a vital component of the MOVEit® family of secure file processing, storage, and transfer products developed by Ipswitch, Inc. Additional help on using MOVEit® DMZ can be located at web page: https://grabit.acs-shc.com/doc/en/help.htm

These products provide comprehensive, integrated, standards-based solutions for secure handling of sensitive information, including financial files, medical records, legal documents, and personal data.

Providers or Service Centers can elect to pick up or drop off your EDI files (batches) for the batch staging queue. This requires a User Id and Password be allocated by the EDI Coordinators office. You can use either of the following methods to access MOVEit® DMZ:

a. A Web browser can be used to obtain access to the MOVEit® DMZ repository at web site http://grabit.acs-shc.com.

b. Using an SFTP Client application referencing the URL grabit.acs-shc.com.

   Note: If you have trouble connecting with the URL grabit.acs-shc.com, you should talk with your technical staff about using the DOS command "nslookup" to get the grabit.acs-shc.com IP Address and drop this value into your URL to connect to MOVEit® DMZ.

   Next you will have to make sure and use the correct port depending on the protocol your company uses. The following table will help identify the port required based on the protocol being used by your company.

IF	THEN
SFTP over SSH	use port 22
SFTP over TLS-P*	use ports 21 and 20
SFTP over TLS-Implicit*	use port 990
SFTP over SSL	use port 443

**NOTE: Both TLS options will use ports 3000 to 3008, but their firewalls should automatically allow this if the initial connections are made to the ports specified above.*

System Availability

The Virginia Medicaid batch transaction submission system is available to providers' 24 hours a day, seven days a week, except for scheduled downtime. Transactions sent in after 5 PM will be processed in the following daily cycle, however, transactions sent in

on Friday must be received before 1 PM to be included in the following week's remittance. The NCPDP Response will normally be available for pickup 1 hour after file submission.

Important Information

BIN Number – ID or number used (use 010900) for network routing

Processor Control Number – Number assigned by processor. Enter DRVAPROD

Provider Identification Number – Use the nine-digit provider identifier number assigned by Virginia Medicaid. If the number currently assigned equals seven digits place two leading zeros in front of the number.

Changes to Accommodate the National Provider Identifier (NPI) –

Only the 10-digit NPI will be allowed to identify providers.

Field:	201-B1
Field Name:	Service Provider ID
Program Specific:	Value = **As of May 23, 2008,** only the 10 Digit Pharmacy NPI Number allowed.

Field:	202-B2
Field Name:	Service Provider ID Qualifier
Program Specific:	Value = **As of May 23, 2008,** 01 (NPI) Only.

Field:	411-DB
Field Name:	Prescriber ID
Program Specific:	Value = **As of May 23, 2008,** only the 10 Digit Prescriber NPI Number allowed.

Field:	466-EZ
Field Name:	Prescriber ID Qualifier
Program Specific:	Value = **As of May 23, 2008,** 01 (NPI) Only

Transaction Format Information

Virginia Medicaid will accept Batch Standard Format Version 1.1. Version 1.1 allows for Telecommunications 3.2 and higher, yet to be HIPAA compliant, the batch transaction must include NCPDP version 5.1. The batch transaction must be submitted using the NCPDP Telecommunications Standard Format Version 5.1 within the NCPDP Batch Standard Format Version 1.1.

Field format values will follow the NCPDP standards for Version 5.1. The following definitions will apply to the data element descriptions for all transaction formats:

- **Field requirement legend:**

Code	Description
M	Designated as **MANDATORY** in accordance with the NCPDP Telecommunication Implementation Guide Version 5.1. These fields must be sent if the segment is required for the transaction.
R	Designated as optional in accordance with the NCPDP Telecommunication Implementation Guide Version 5.1, but designated as **REQUIRED** by this program. These fields must be sent if the segment is required for the transaction.
RW	Designated as optional in accordance with the NCPDP Telecommunication Implementation Guide Version 5.1, but designated as **REQUIRED WHEN** by this program. These fields must be sent if the condition described is met and the segment is required for the transaction.
O	Designated as optional in accordance with the NCPDP Telecommunication Implementation Guide Version 5.1, but designated as **NOT REQUIRED** by this program. It is not necessary to send these fields.

Supported Transactions

Other valid transaction codes are available, Virginia Medicaid supports the following:

Transaction Type	*Description*	*Transaction Codes*
Original Claim	A claim is transmitted for the first time or after error correction of a denied claim. Also used when overriding a rejection.	B1
Claim Reversal	A claim reversal notifies Virginia Medicaid that the prescription was not dispensed or if a quantity correction is required and voids the claim.	B2

Batch Transaction Submission

Data Element Definition

All data elements used in the Virginia Medicaid batch transaction submission system adhere to industry standards as defined by NCPDP. It should be noted that the actual data and format to be entered into your pharmacy computer are dependent upon the design of the particular software package that is used by your pharmacy, and is often "translated" by the software into the NCPDP requirements.

The following fields are clarified beyond the NCPDP standard definition to avoid any confusion concerning Virginia Medicaid requirements:

- ***Prescriber ID Number***

As of May 23, 2008, enter the NPI for the Prescribing Physician.
As of May 23, 2008, the qualifier must be 01 (NPI).

Batch Standard Format

In order to submit a Pharmacy batch transaction using the NCPDP Batch Standard, you must include a transaction header, transaction detail and a transaction trailer.

Transaction Header Definition

Field	*ID*	*FIELD-NAME*	*Type*	*Length*	*START*	*END*	*VALUE*
880	K4	TEXT INDICATOR	AN	1	1	1	START OF TEXT (STX)=X'02'
701		SEGMENT IDENTIFIER	AN	2	2	3	00-FILE CONTROL (HEADER)
880	K6	TRANSMISSION TYPE	AN	1	4	4	T=TRANSACTION R=RESPONSE E=ERROR
880	K1	SENDER ID	AN	24 (3)	5	28	VIRGINIA MMIS SUBMITTER ID SERVICE CENTER CODE, UP TO 4 ALPHA-NUMERIC CODE SPACE FILL REMAINING
806	5C	BATCH NUMBER	N	7	29	35	ASSIGNED BY SENDER. MATCHES TRAILER. TO BE RETURNED IN RESPONSE OR ERROR FILE FROM PROCESSOR.
880	K2	CREATION DATE	N	8	36	43	FORMAT=CCYYMMDD
880	K3	CREATION TIME	N	4	44	47	FORMAT=HHMM
702		FILE TYPE	AN	1	48	48	P=PRODUCTION T=TEST
102	A2	VERSION/RELEASE NUMBER	AN	2	49	50	VERSION 1.1 "11" – VERSION/RELEASE FOR BATCH STANDERD
880	K7	RECEIVER ID	AN	24	51	74	DRVAPROD
880	K4	TEXT INDICATOR	AN	1	75	75	END OF TEXT (ETX)=X'03 '

Transaction Header Notes

1. Only one Header record per file.
2. Transmission Type "T" is required when the pharmacy is submitting a batch. Transmission Type "E" is required when the entire batch has been rejected by the processor or switch. Transmission Type "R" is returned to the pharmacy to denote the file contains responses to claims.
3. Sender ID - assigned by Virginia MMIS. This ID reflects valid enrollment between trading partners for batch file submission and consists of up to 4 bytes Virginia MMIS assigned service center.
4. Batch Number is assigned by the sender and must match the trailer Batch Number field.
5. The Batch Number on the Response file should be the same Batch Number from the Request file.

Transaction Detail Definition

Field	*ID*	*FIELD NAME*	*Type*	*Length*	*START*	*END*	*VALUE*
880	K4	TEXT INDICATOR	AN	1	1	1	START OF TEXT (STX)=X'02'.
701		SEGMENT	AN	2	2	3	G1=DETAIL DATA RECORD.
880	K5	TRANSACTION REFERENCE NUMBER	AN	10	4	13	A REFERENCE NUMBER OR CLAIM NUMBER ASSIGNED BY THE CLAIM PROVIDER TO EACH OF THE DATA RECORDS IN THE BATCH. THE PURPOSE OF THIS NUMBER IS TO FACILITATE THE PROCESS OF MATCHING THE CLAIM RESPONSE TO THE CLAIM. THE TRANSACTION REFERENCE NUMBER ASSIGNED TO THE CLAIM IS BEING RETURNED WITH THE CLAIM'S CORRESPONDING REFERENCE NUMBER.
		NCPDP DATA RECORD		VARIES	14	VARIES	REFER TO THE FOLLOWING PAGES.
880	K4	TEXT INDICATOR	AN	1	VARIES	VARIES	END OF TEXT (ETX)=X'03 '

Transaction Detail Notes

1. The data record to be transmitted in this batch standard will follow the NCPDP Telecommunication Standard Version 5.1 of the Telecommunication Standard.

2. The Transaction Reference Number or Claim Number is a unique number assigned by the Pharmacy to identify a pharmacy's individual data record in the batch. When the processor receives the file and begins processing the claims, the Transaction Reference Number must be returned with the response generated by Virginia Medicaid. The Transaction Reference Number is used to explicitly tie a response back to the original claim.

Transaction Trailer Definition

Field	*ID*	*FIELD NAME*	*Type*	*Length*	*START*	*END*	*VALUE*
880	K4	TEXT INDICATOR	AN	1	1	1	START OF TEXT (STX)=X'02"
701		SEGMENT IDENTIFIER	AN	2	2	3	99=FILE TRAILER
806	5C	BATCH NUMBER	N	7	4	10	ASSIGNED BY SENDER. MATCHES HEADER
751		RECORD COUNT	N	10	11	20	
504	F4	MESSAGE	AN	35	21	55	
880	K4	TEXT INDICATOR	AN	1	56	56	END OF TEXT (ETX)=X"03"

Transaction Trailer Notes

1. Only one Trailer Record per file.
2. Batch number must match the Batch number field in the header record.
3. The record count field includes the total number of records in the batch, including the header and trailer records.
4. The message field can be used for information about testing or any other information that needs to be sent regarding the batch. This field should only contain informational data and should not contain required data 5.1.
5. The maximum number of records in a file is 9,999,999,999, including Transaction Header and Transaction Trailer.

NCPDP Data Specifications

Transmission (Header) Segments

Transaction Header Segment

	TRANSACTION HEADER SEGMENT		
Field	**Field Name**	**Mandatory Required Required When Optional/Not Required**	**Values Supported**
1Ø1-A1	BIN NUMBER	M	010900
1Ø2-A2	VERSION/RELEASE NUMBER	M	51
1Ø3-A3	TRANSACTION CODE	M	B1 = Billing B2 = Reversal
1Ø4-A4	PROCESSOR CONTROL NUMBER	M	DRVAPROD
1Ø9-A9	TRANSACTION COUNT	M	1 = One occurrence 2 = Two occurrences 3 = Three occurrences 4 = Four occurrences
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	M	∅1 = NPI
2Ø1-B1	SERVICE PROVIDER ID	M	Pharmacy NPI
4Ø1-D1	DATE OF SERVICE	M	
11Ø-AK	SOFTWARE VENDOR/CERTIFICATION ID	M	∅ is accepted

Insurance Segment

	INSURANCE SEGMENT		
Field	**Field Name**	**Mandatory Required Required When Optional/Not Required**	**Values Supported**
111-AM	SEGMENT IDENTIFICATION	M	∅4
3Ø2-C2	CARDHOLDER ID	M	Medicaid ID
312-CC	CARDHOLDER FIRST NAME	R	REQUIRED; Cardholder is Patient
313-CD	CARDHOLDER LAST NAME	R	REQUIRED; Cardholder is Patient
314-CE	HOME PLAN	O	
524-FO	PLAN ID	O	
3Ø9-C9	ELIGIBILITY CLARIFICATION CODE.	O	
336-8C	FACILITY ID	O	
3Ø1-C1	GROUP ID	O	
3Ø3-C3	PERSON CODE	O	
3Ø6-C6	PATIENT RELATIONSHIP CODE	O	

Patient Segment

	PATIENT SEGMENT		
Field	**Field Name**	**Mandatory Required Required When Optional/Not Required**	**Values Supported**
111-AM	SEGMENT IDENTIFICATION	M	∅1
331-CX	PATIENT ID QUALIFIER	O	
332-CY	PATIENT ID	O	
3Ø4-C4	DATE OF BIRTH	R	REQUIRED Format = CCYYMMDD
3Ø5-C5	PATIENT GENDER CODE.	O	
31Ø-CA	PATIENT FIRST NAME	O	
311-CB	PATIENT LAST NAME.	O	
322-CM	PATIENT STREET ADDRESS	O	
323-CN	PATIENT CITY ADDRESS	O	
324-CO	PATIENT STATE / PROVINCE ADDRESS	O	
325-CP	PATIENT ZIP/POSTAL ZONE	O	
326-CQ	PATIENT PHONE NUMBER	O	
3Ø7-C7	PATIENT LOCATION	O	
333-CZ	EMPLOYER ID	O	
334-1C	SMOKER / NON-SMOKER CODE	O	
335-2C	PREGNANCY INDICATOR	RW	REQUIRED WHEN specific drug coverage consideration and/or to waive copay. 2 = Pregnant

Transaction (Prescription) Segments

Claim Segment

	CLAIM SEGMENT		
Field	**Field Name**	**Mandatory Required Required When Optional/Not Required**	*Values Supported*
111-AM	SEGMENT IDENTIFICATION	M	Ø7
455-EM	PRESCRIPTION NUMBER QUALIFIER	M	1 = Rx Billing
4Ø2-D2	PRESCRIPTION NUMBER	M	
436-E1	PRODUCT ID QUALIFIER	M	Ø3 = NDC
4Ø7-D7	PRODUCT ID	M	
456-EN	ASSOCIATED PRESCRIPTION NUMBER	RW	REQUIRED WHEN "Partial Fill" situation.
457-EP	ASSOCIATED PRESCRIPTION DATE	RW	REQUIRED WHEN "Partial Fill" situation.
458-SE	PROCEDURE MODIFIER CODE COUNT.	O	
459-ER	PROCEDURE MODIFIER CODE	O	
442-E7	QUANTITY DISPENSED	R	REQUIRED
4Ø3-D3	FILL NUMBER	R	REQUIRED Ø = Original dispensing Ø1-99 = Refill number
4Ø5-D5	DAYS SUPPLY	R	REQUIRED
4Ø6- D6	COMPOUND CODE	R	REQUIRED Ø = Not Specified 1 = Not a compound 2 = Compound
4Ø8-D8	DISPENSE AS WRITTEN (DAW)/PRODUCT SELECTION CODE	R	REQUIRED
414-DE	DATE PRESCRIPTION WRITTEN.	R	REQUIRED
415-DF	NUMBER OF REFILLS AUTHORIZED	O	.
419-DJ	PRESCRIPTION ORIGIN CODE	O	
42Ø-DK	SUBMISSION CLARIFICATION CODE	O	
46Ø-ET	QUANTITY PRESCRIBED	O	
3Ø8-C8	OTHER COVERAGE CODE.	R	REQUIRED Ø = Not Specified Ø1 = No Other Coverage Ø2 = Other coverage exists – payment collected Ø3 = Other coverage exists – claim not covered Ø4 = Other coverage exists – payment not collected Ø5 = Managed care plan denial Ø6 = Other coverage denied-not participating provider Ø7 = Other coverage exists – not in effect on DOS Ø8 = Claim is billing for copay
429-DT	UNIT DOSE INDICATOR	RW	REQUIRED WHEN dispensing Manufacturer Unit Dose 2 = Manufacturer Unit Dose
453-EJ	ORIGINALLY PRESCRIBED PRODUCT/SERVICE ID QUALIFIER	O	
445-EA	ORIGINALLY PRESCRIBED PRODUCT/SERVICE CODE	O	
446-EB	ORIGINALLY PRESCRIBED QUANTITY	O	
33Ø-CW	ALTERNATE ID.	O	

	CLAIM SEGMENT		
Field	**Field Name**	**Mandatory Required Required When Optional/Not Required**	*Values Supported*
454-EK	SCHEDULED PRESCRIPTION ID NUMBER	O	
6ØØ-28	UNIT OF MEASURE	O	
418-DI	LEVEL OF SERVICE	RW	REQUIRED WHEN identifying emergency conditions. ∅3 = Emergency
461-EU	PRIOR AUTHORIZATION TYPE CODE	RW	REQUIRED WHEN overriding the "Dosage Limit Exemption" for Anti-Ulcer medication. 5 = Exemption from Rx.
462-EV	PRIOR AUTHORIZATION NUMBER SUBMITTED .	RW	REQUIRED WHEN overriding the "Dosage Limit Exemption" for Anti-Ulcer medications. 5555555552∅= Initial Therapy 55555555521= Gastroesophageal Reflux Disease (GERD) 55555555522= Pathological Hypersecretory Syndrome 55555555523= Zollinger-Ellison Syndrome 55555555524= Unhealed Ulcer (gastric,duodenal,peptic) 55555555525= History of Upper GI Bleeding 55555555526= Erosive Esophagitis
463-EW	INTERMEDIARY AUTHORIZATION TYPE ID.	O	
464-EX	INTERMEDIARY AUTHORIZATION ID.	O	
343-HD	DISPENSING STATUS	RW	REQUIRED WHEN "Partial Fill" situation. Blank = Not Specified P = Partial Fill C = Completion of Partial Fill
344-HF	QUANTITY INTENDED TO BE DISPENSED	RW	REQUIRED WHEN "Partial Fill" situation. This is the **Metric Decimal Quantity** of medication that would be dispensed on an original fill if inventory were available. It is used in association with a "P" or "C" in DISPENSING STATUS field.
345-HG	DAYS SUPPLY INTENDED TO BE DISPENSED	RW	REQUIRED WHEN "Partial Fill" situation. This is the **Days Supply** for the Metric Decimal Quantity of medication that would be dispensed on an original fill if inventory were available. It is used in association with a "P" or "C" in DISPENSING STATUS field.

Pricing Segment

PRICING SEGMENT			
Field	**Field Name**	**Mandatory Required Required When Optional/Not Required**	**Values Supported**
111-AM	SEGMENT IDENTIFICATION	M	11
4Ø9-D9	INGREDIENT COST SUBMITTED	O	
412-DC	DISPENSING FEE SUBMITTED	O	
477-BE	PROFESSIONAL SERVICE FEE SUBMITTED	O	
433-DX	PATIENT PAID AMOUNT SUBMITTED	O	
438-E3	INCENTIVE AMOUNT SUBMITTED	O	
478-H7	OTHER AMOUNT CLAIMED SUBMITTED COUNT	O	
479-H8	OTHER AMOUNT CLAIMED SUBMITTED QUALIFIER	O	
48Ø-H9	OTHER AMOUNT CLAIMED SUBMITTED	O	
481-HA	FLAT SALES TAX AMOUNT SUBMITTED	O	
482-GE	PERCENTAGE SALES TAX AMOUNT SUBMITTED.	O	
483-HE	PERCENTAGE SALES TAX RATE SUBMITTED	O	
484-JE	PERCENTAGE SALES TAX BASIS SUBMITTED	O	
426-DQ	USUAL AND CUSTOMARY CHARGE	R	REQUIRED. Format = s$$$$$$cc
43Ø-DU	GROSS AMOUNT DUE.	O	
423-DN	BASIS OF COST DETERMINATION.	O	

Prescriber Segment

PRESCRIBER SEGMENT			
Field	**Field Name**	**Mandatory Required Required When Optional/Not Required**	**Values Supported**
111-AM	SEGMENT IDENTIFICATION	M	∅3
466-EZ	PRESCRIBER ID QUALIFIER	M	∅1 = NPI
411-DB	PRESCRIBER ID	R	Prescriber NPI
467-1E	PRESCRIBER LOCATION CODE.	O	
427-DR	PRESCRIBER LAST NAME.	O	
498-PM	PRESCRIBER PHONE NUMBER	O	
468-2E	PRIMARY CARE PROVIDER ID QUALIFIER	O	
421-DL	PRIMARY CARE PROVIDER ID	O	
469-H5	PRIMARY CARE PROVIDER LOCATION CODE.	O	
47Ø-4E	PRIMARY CARE PROVIDER LAST NAME	O	

COB/Other Payments Segment

COB/OTHER PAYMENTS SEGMENT			
Field	**Field Name**	**Mandatory Required Required When Optional/Not Required**	**Values Supported**
111-AM	SEGMENT IDENTIFICATION	M	∅5
337-4C	COORDINATION OF BENEFITS/OTHER PAYMENTS COUNT	M (Max = 1 for FFS, 2 for MCOs)	Defined as "Count of other payment occurrences".
338-5C	OTHER PAYER COVERAGE TYPE	M***R*** (Max = 1 for FFS, 2 for MCOs)	BLANK = Not Specified ∅1 = Primary ∅2 = Secondary ∅3 = Tertiary Maximum # of occurrences supported = 1, except for MCO encounters.
339-6C	OTHER PAYER ID QUALIFIER	RW	REQUIRED WHEN other coverage code = 02 or 08
34Ø-7C	OTHER PAYER ID	RW	REQUIRED WHEN other coverage code = 02 or 08
443-E8	OTHER PAYER DATE	RW	REQUIRED WHEN other coverage code = 02 or 08
341-HB	OTHER PAYER AMOUNT PAID COUNT	RW	REQUIRED WHEN amount collected from other payer.
342-HC	OTHER PAYER AMOUNT PAID QUALIFIER	RW	REQUIRED WHEN Other Payer Amount Paid Count and Other Payer Amount Paid are used. ∅8= Sum of All Reimbursements. If MCO encounter, use ∅7 to show actual MCO payment.
431-DV	OTHER PAYER AMOUNT PAID	RW	REQUIRED WHEN Other Payer Amount Paid Count and Other Payer Amount Paid Qualifier are used. Maximum # of occurrences supported = 1 Format = s$$$$$$cc
471-5E	OTHER PAYER REJECT COUNT	O	
472-6E	OTHER PAYER REJECT CODE	O	

DUR/PPS Segment

	DUR/PPS SEGMENT		
Field	**Field Name**	**Mandatory Required Required When Optional/Not Required**	**Values Supported**
111-AM	SEGMENT IDENTIFICATION	M	∅8
473-7E	DUR/PPS CODE COUNTER	RW***R*** (Max = 2)	REQUIRED WHEN identifying a drug utilization review or professional pharmacy service occurrence. Maximum # of occurrences supported = 2
439-E4	REASON FOR SERVICE CODE	RW***R*** (Max = 2)	REQUIRED WHEN identifying the type of utilization conflict detected or the reason for the pharmacist's professional service. Maximum # of occurrences supported = 2 AD=Additional Drug Needed AN=Prescription Authentication AR=Adverse Drug Reaction AT=Additive Toxicity CD=Chronic Disease Management CH=Call Help Desk CS=Patient Complaint/Symptom DA=Drug-Allergy DC=Drug-Disease (Inferred) DD=Drug-Drug Interaction DF=Drug-Food interaction DI=Drug Incompatibility DL=Drug-Lab Conflict DM=Apparent Drug Misuse DS=Tobacco Use ED=Patient Education/Instruction ER=Overuse EX=Excessive Quantity HD=High Dose IC=Iatrogenic Condition ID=Ingredient Duplication LD=Low Dose LK=Lock In Recipient LR=Underuse MC=Drug-Disease (Reported) MN=Insufficeint Duration MS=Missing Information/Clarification MX=Excessive Duration NA=Drug Not Available NC=Non-covered Drug Purchase ND=New Disease/Diagnosis NF=Non-Formulary Drug NN=Unnecessary Drug NP=New Patient Processing NR=Lactation/Nursing Interaction NS=Insufficient Quantity OH=Alcohol Conflict PA=Drug-Age PC=Patient Question/Concern PG=Drug-Pregnancy PH=Preventive Health Care PN=Prescriber Consultation

	DUR/PPS SEGMENT		
Field	**Field Name**	**Mandatory Required Required When Optional/Not Required**	**Values Supported**
			PP=Plan Protocol PR=Prior Adverse Reaction PS=Product Selection Opportunity RE=Suspected Environmental Risk RF=Health Provider Referral
44Ø-E5	PROFESSIONAL SERVICE CODE	RW***R*** (Max = 2)	REQUIRED WHEN identifying the pharmacist intervention when a conflict code has been identified or service has been rendered. Maximum # of occurrences supported = 2 If the provider enters any INTERVENTION CODES *NOT* ***SPECIFIED as ONE OF THE FOLLOWING***, the system will capture and report them, but will ***NOT*** override the edit. Values supported are: ØØ=No intervention AS=Patient assessment CC=Coordination of care DE=Dosing evaluation/determination FE=Formulary enforcement GP=Generic product selection MA=Medication administration MØ=Prescriber consulted MR=Medication review PE=Patient education/instruction PH=Patient medication history PM=Patient monitoring PØ=Patient consulted PT=Perform laboratory test RØ=Pharmacist consulted other source RT=Recommend laboratory test SC=Self-care consultation SW=Literature search/review TC=Payer/processor consulted TH=Therapeutic product interchange
441-E6	RESULT OF SERVICE CODE	RW***R*** (Max = 2)	REQUIRED WHEN describing action taken by a pharmacist in response to a conflict or the result of a pharmacist's professional service. Maximum # of occurrences supported = 2 All OUTCOME CODES will be captured and reported. The values are: ØØ=Not Specified 1A=Filled As Is, False Positive 1B=Filled Prescription As Is 1C=Filled, With Different Dose 1D=Filled, With Different Directions 1E=Filled, With Different Drug 1F=Filled, With Different Quantity 1G=Filled, With Prescriber Approval 1H=Brand-to-Generic Change 1J=Rx-to-OTC Change 1K=Filled with Different Dosage Form 2A=Prescription Not Filled

	DUR/PPS SEGMENT		
Field	**Field Name**	**Mandatory Required Required When Optional/Not Required**	**Values Supported**
			2B=Not Filled, Directions Clarified 3A=Recommendation Accepted 3B=Recommendation Not Accepted 3C=Discontinued Drug 3D=Regimen Changed 3E=Therapy Changed 3F=Therapy Changed-cost increased acknowledged 3G=Drug Therapy Unchanged 3H=Follow-Up/Report 3J=Patient Referral 3K=Instructions Understood 3M=Compliance Aid Provided 3N=Medication Administered
474-8E	DUR/PPS LEVEL OF EFFORT	O	
475-J9	DUR CO-AGENT ID QUALIFIER	O	
476-H6	DUR CO-AGENT ID	O	

Compound Segment

	COMPOUND SEGMENT		
Field	**Field Name**	**Mandatory Required Required When Optional/Not Required**	**Values Supported**
111-AM	SEGMENT IDENTIFICATION	M	1∅
45Ø-EF	COMPOUND DOSAGE FORM DESCRIPTION CODE	M	
451-EG	COMPOUND DISPENSING UNIT FORM INDICATOR	M	1=Each, 2=Grams, 3=Milliliters
452-EH	COMPOUND ROUTE OF ADMINISTRATION	M	
447-EC	COMPOUND INGREDIENT COMPONENT COUNT	M	Count of compound product IDs (both active and inactive) in the compound mixture submitted Max=13
488-RE	COMPOUND PRODUCT ID QUALIFIER	M***R*** (Max = 13)	Maximum # of occurrences supported = 13 ∅3 = NDC
489-TE	COMPOUND PRODUCT ID	M***R*** (Max = 13)	Maximum # of occurrences supported = 13
448-ED	COMPOUND INGREDIENT QUANTITY	M***R*** (Max = 13)	Maximum # of occurrences supported = 13
449-EE	COMPOUND INGREDIENT DRUG COST	O	
49Ø-UE	COMPOUND INGREDIENT BASIS OF COST DETERMINATION	O	

Batch Response Format

Introduction

A Batch Response file is returned for every Batch Claim file received. The Batch Response will indicate whether the entire Batch Claim file is rejected ("batch error response") or accepted. When the Batch Claim file is accepted, the Batch Response file ("standard response") will contain individual accept/reject responses for each claim. Response Reject Codes indicate errors for NCPDP defined syntax, required fields, or valid codes only. Claims that are accepted will be submitted for adjudication processing.

A "batch error response" is returned when there is a problem with the Batch Transaction Header, Batch Transaction Detail (but not the NCPDP Data Record), or Batch Transaction Trailer. In this situation, the entire batch is rejected and the Batch Error Response file contains only Batch Response Header and Batch Response Trailer. Field 880-K6 in the Header contains "E" (Error). Field 504-F4 in the Trailer contains the RESPONSE REJECT MESSAGE, which is a free text description of the error.

A "standard response" is returned for each transmitted claim and reversal when the entire batch is not rejected. In this situation, the Batch Error Response file contains a Batch Response Header, multiple Batch Response Detail records (one for each claim or reversal in the original Batch Transaction Request), and a Batch Response Trailer. Field 880-K6 in the Header contains "R" (Response).

Batch Response Detail Records

Claim Captured Response acknowledges receipt of a claim that has all data fields with correct syntax. It will be processed further for adjudication.

Claim Rejected Response reports a claim that has one or more data fields with incorrect data and will not be processed further. It will report up to 99 Reject Codes. Reject Codes identify the field in error but do not identify the type of error.

Response Reject Codes

Response Reject Codes are generated when a field has wrong format, is too long, is required but not present, or has an invalid code. These edits are based on the NCPDP Data Specifications:
- field format is Numeric, data contains non-numeric characters
- optional fields that exceed the maximum defined data length
- a required field contains only spaces
- a field has an incorrect code value

Response Status Codes

A Response contains two Status Codes: a Response Status (Header) which applies to fields in the Header Sections, and a Response Status (Prescription) which applies to fields in the Claim Sections.

TYPE OF RESPONSE	*TRANSMISSION RESPONSE STATUS*	*TRANSACTION RESPONSE STATUS*	*COMMENTS*
Transaction Captured	A	C	All field edits are good.
Transaction Rejected	A	R	Field errors in the Claim Sections.
Transmission Rejected	R	R	Field errors in the Header Sections. Claim Sections may or may not have errors.

Response Header Definition

Field	*ID*	*FIELD-NAME*	*TYPE*	*LENGTH*	*START*	*END*	*VALUE*
880	K4	TEXT INDICATOR	AN	1	1	1	START OF TEXT (STX)=X'02'
701		SEGMENT IDENTIFIER	AN	2	2	3	00-FILE CONTROL (HEADER)
880	K6	TRANSMISSION TYPE	AN	1	4	4	R=RESPONSE E=ERROR (ENTIRE BATCH REJECTED)
880	K1	SENDER ID	AN	24	5	28	VIRGINIA MMIS SUBMITTER ID SERVICE CENTER CODE, UP TO 4 ALPHA-NUMERIC CODE SPACE FILL REMAINING
880	5C	BATCH NUMBER	N	7	29	35	ASSIGNED BY SENDER. MATCHES TRAILER. TO BE RETURNED IN RESPONSE OR ERROR FILE FROM PROCESSOR.
806	K2	CREATION DATE	N	8	36	43	FORMAT=CCYYMMDD
880	K3	CREATION TIME	N	4	44	47	FORMAT=HHMM
702		FILE TYPE	AN	1	48	48	P=PRODUCTION T=TEST
102	A2	VERSION/RELEASE NUMBER	AN	2	49	50	VERSION 1.1 "11" VERSION/ RELEASE OF BATCH STANDERD
880	K7	RECEIVER ID	AN	24	51	74	DRVAPROD
880	K4	TEXT INDICATOR	AN	1	75	75	END OF TEXT (ETX)=X'03'

Response Detail Definition

Field	*ID*	*FIELD-NAME*	*TYPE*	*LENGTH*	*START*	*END*	*VALUE*
880	K4	TEXT INDICATOR	AN	1	1	1	START OF TEXT (STX)=X'02'.
701		SEGMENT	AN	2	2	3	G1=DETAIL DATA RECORD.
880	K5	TRANSACTION REFERENCE NUMBER	AN	10	4	13	A TEN DIGIT NUMBER THAT IS UNIQUE AND IDENTIFIES THE INDIVIDUAL PRESCRIPTION CLAIM. SAME VALUE AS THAT SUBMITTED IN THE CLAIM FILE.
		NCPDP DATA RECORD		VARIES	14	VARIES	REFER TO THE FOLLOWING PAGES.
880	K4	TEXT INDICATOR	AN	1	VARIES	VARIES	END OF TEXT (ETX)=X"03"

Response Trailer Definition

Field	*ID*	*FIELD NAME*	*Type*	*Length*	*START*	*END*	*VALUE*
880	K4	TEXT INDICATOR	AN	1	1	1	START OF TEXT (STX)=X'02"
701		SEGMENT IDENTIFIER	AN	2	2	3	99=FILE TRAILER
806	5C	BATCH NUMBER	N	7	4	10	MATCHES HEADER
751		RECORD COUNT	N	10	11	20	INCLUDES HEADER AND TRAILER.
504	F4	MESSAGE	AN	35	21	55	IF ENTIRE BATCH REJECTED, FREE-TEXT DESCRIPTION OF REASON.
880	K4	TEXT INDICATOR	AN	1	56	56	END OF TEXT (ETX)=X"03"

Telecommunication Standard 5.1

Telecommunication Standard 5.1 – Transmission Level

Response Header Segment							
Field	*ID*	*FIELD-NAME*	*TYPE*	*LENGTH*	*START*	*END*	*VALUE*
102	A2	VERSION/RELEASE NUMBER	AN	2	1	2	"51"
103	A3	TRANSACTION CODE	AN	2	3	4	"B1" – Billing, "B2" - Reversal
109	A9	TRANSACTION COUNT	AN	1	5	5	1 – One Occurrence, 2 – Two Occurrences, 3 – Three Occurrences, 4 – Four Occurrences. Returned from the Request Transaction Header Segment
501	F1	HEADER RESPONSE STATUS	AN	1	6	6	"A" – Accepted, "R" - Rejected
202	B2	SERVICE PROVIDER ID QUALIFIER	AN	2	7	8	Returned from the Request Transaction Header Segment
201	B1	SERVICE PROVIDER ID	AN	15	9	23	Returned from the Request Transaction Header Segment
401	D1	DATE OF SERVICE	D	8	24	31	Returned from the Request Transaction Header Segment

Telecommunication Standard 5.1 – Transaction Level

Response Status Segment							
Field	***ID***	***FIELD-NAME***	***TYPE***	***LENGTH***	***START***	***END***	***VALUE***
		GROUP SEPARATOR		1	1	1	
		SEGMENT SEPARATOR		1	2	2	
111	AM	SEGMENT IDENTIFICATION	AN	2	3	4	"21" – Response Status Segment
112	AN	TRANSACTION RESPONSE STATUS	AN	1	5	5	"C" – Captured, "R" - Rejected
503	F3	AUTHORIZATION NUMBER	AN	20	6	25	Number assigned by the processor to identify an authorized transaction. Accepted transactions only.
510	FA	REJECT COUNT	AN	2	26	27	Count of "Reject Code" (511-FB) occurrences
511	FB	REJECT CODE	N	2	28	29	Code indicating the error encountered
546	4F	REJECT FIELD OCCURRENCE INDICATOR	N	2	30	31	Identifies the counter number or occurrence of the field that is being rejected. Used to indicate rejects for repeating fields.
Response Claim Segment							
		SEGMENT SEPARARTOR		1			
111	AM	SEGMENT IDENTIFICATION	AN	2			"22" – Response Claim Segment
455	EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	AN	1			Prescription/Service Reference Number Qualifier returned from the Request Transaction Claim Segment
402	D2	PRESCRIPTION/SERVICE REFERENCE NUMBER	N	7			RX Number returned from the Request Transaction Claim Segment